BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the amendment of ARM 24.29.1402, 24.29.1404, 24.29.1406, 24.29.1416, 24.29.1427, 24.29.1430, 24.29.1431, and 24.29.1522, the amendment and transfer of 24.29.1504, and the adoption of NEW RULE I, all related to the workers' compensation medical fee schedule for facilities	)))))))))	NOTICE OF AMENDMENT, AMENDMENT AND TRANSFER, AND ADOPTION

TO: All Concerned Persons

1. On August 28, 2008, the Department of Labor and Industry (department) published MAR Notice No. 24-29-231 regarding the public hearing on the proposed amendment, amendment and transfer, and adoption of the above-stated rules at page 1779 of the 2008 Montana Administrative Register, issue no. 16.

2. On September 19, 2008, the department held a public hearing in Helena at which time members of the public made oral comments. Additional written comments were received during the comment period.

3. The department has thoroughly considered the comments and testimony received from the public. The following is a summary of the public comments received and the department's response to those comments:

Comment 1: The Montana Hospital Association (MHA) recommends the department adopt the proposed facility fee schedule using a phase-in approach to protect against unintended shifts in payment amounts and to allow all parties to become more familiar with the proposal by gaining experience with payment calculations. It recommends that a cross section of payers price a sample of claims and share them with the hospitals to verify that the calculations can be accomplished accurately.

Response 1: Because the department has designed the changes to be budget neutral to the overall system, because workers' compensation cases are a relatively small percentage of the total caseload for hospitals, and because hospitals and some payers are already familiar with Medicare billing methods, the department believes a phase-in approach is not necessary. The department has communicated with as many of the payers as possible and believes payers are ready to implement the proposed fee schedule as noticed. In order to provide affected parties lead time to prepare for the new system, the department is extending the effective date of the proposed rules to December 1, 2008 and amends rules 24.29.1427, 24.29.1431, and proposed New Rule I as indicated below to reflect this change. The department notes that recourse concerning disputes as they arise between providers and payers are handled through the mediation process.

Comment 2: The MHA and Community Medical Center (CMC) are concerned whether the new system will provide adequate payments or will cause payments to drop from existing levels. The groups further comment they believe that the department's data are inadequate and that calibration of a new payment system to determine whether the new system results in adequate payments requires more analysis than is allowed using the few hundred claims used by the department.

Response 2: The department renoticed the proposed fee schedule in an effort to allow hospitals additional time to analyze its financial impacts. As a result, the department received data from a total of five hospitals. All the data received were in line with the department's analysis. The department also received anecdotal responses which are not amenable to analysis. In trying to ensure a reasonable profit over cost, the department has set the overall reimbursement at 65 percent above Medicare. This reimbursement level considers the combination of payments under MS-DRGs, the payments for outliers and the payments for implants. The department believes that setting the reimbursement at this rate assures that any additional financial burden is minimal. Additionally, the National Council of Compensation Insurers (NCCI) has analyzed the proposed fee schedule and determined hospital outpatient reimbursements will not decrease overall. However, the department acknowledges that Ambulatory Surgery Centers will experience a decrease as they were previously reimbursed at 100 percent of charges.

Comment 3: The MHA and CMC comment that both believe expensive cases and implantable devices will always be substantially underpaid. It also asserts that any new system should not pull more funds out of the hospitals in order to avoid cost shifting to other types of patients. CMC further notes that the proposed regulations are absent of an outlier policy for outpatient cases. CMC requests the department to prepare a detailed analysis by facility showing the differences in payments from the current methodology versus the proposed payment system.

Response 3: The department notes that the previous discount factor system for hospital facilities did not address equity of services across the state. In an attempt to level the playing field from the existing reimbursement system, the department has developed the proposed fee schedule to reimburse all facilities based on costs rather than charges for services. The intent in adopting the MS-DRG and APC system is to obtain equitable payments across the system rather than on an individual hospital or ambulatory surgery center basis. The department acknowledges that some facilities will have increases and some will have decreases. Because the reimbursement is 65 percent above Medicare, the department does not believe the fee schedule will cause cost shifting to other patients. However, the department intends to evaluate and review any impact or unintended consequences and will consider changes at a later date if the data indicate any changes are necessary. Finally, the department removed outliers for outpatient cases because feedback from ASCs indicated that cases that would meet the threshold for an outlier payment become inpatient.

Comment 4: The MHA recommends that the department specify in ARM 24.29.1406 which version of the MS-DRG is included in the regulation.

Response 4: The department agrees that the version should be specified, but believes New Rule I (ARM 24.29.1432) and the department's web site are more appropriate places. Certain rules are designed to be updated annually and ARM 24.29.1406 is not one of those rules. The department has placed the appropriate version it is adopting on its web site and amended New Rule I as indicated below.

Comment 5: The MHA believes the proposed outlier threshold of three times the base price in New Rule I(11)(d) is inadequate. The group believes this method transfers the risk for expensive medical care to a hospital and does not consider whether the burden of outlier cases falls on a few particular hospitals.

Response 5: The department notes that outlier cases, by definition, are unusual and the frequency of outlier cases is low. The department concludes that using the data available to the department, the proposed rates, including the outlier threshold, provide (in the aggregate) a reasonable rate of reimbursement for facilities. The department believes that the proposed rates (including the outlier threshold) represent a reasonable approach to setting reimbursement levels and methods, even if the approach is not viewed by all system participants as the ideal approach. The department intends to evaluate and review any impact or unintended consequences and will consider changes at a later date if the data indicate any changes are necessary.

Comment 6: The MHA comments the method proposed to reimburse for high cost implantable devices poses problems as it imposes a disclosure requirement on the hospitals that is prohibited under their purchasing contracts. The group states device manufacturers provide discounts to hospitals, but the amount of discount is a trade secret. The group suggests the proposal poses a considerable barrier to service and that a hospital that is barred from disclosing its discount might provide an implantable device acquired outside of its contract, which would cost the payer a much higher cost. MHA recommends the department modify New Rule I(11)(e) to provide a standard discounted charge payment for implantable devices.

Response 6: The department believes it is reasonable to require invoices for implantable devices and has developed the proposed fee schedule based on cost rather than a discount from charges. The department notes that workers' compensation jurisdictions in nine other states require an invoice to allocate payment based on cost. The department notes that insurers are subject to privacy laws concerning disclosure of any health information or proprietary trade secret information they receive. The department has amended New Rule I by adding a statement similar to other states to clarify that private information must remain private when obtained by an insurer. The department has been assured by several hospital and ACS representatives that submission of invoices would not violate their contracts.

Comment 7: CMC suggests the complexity of the proposed rules will lead to manual review of payments which increases labor costs for manual pricing, coding, monitoring, billing, and follow up. The group also points out the department will be asked to intervene and enforce regulations. The group requests the department to provide facilities with assurances that the reviews will be conducted in an expedient manner, have experts available who understand the system, and devote the necessary amount of time to the inquiries, as well as provide education to the payer community regarding proper processing and payments.

Response 7: The department will devote the necessary amount of resources to assist providers and payers in understanding the new system and in resolving disputes.

Comment 8: CMC requests the department to consider alternatives to the proposed rules that would be more in line with commercial insurance payers and suggests this may include accessing preferred provider organization ("PPO") networks or developing a similar network.

Response 8: The department notes that under current law, insurers may contract with PPOs, and that PPO contracts are not subject to the department's fee schedules. The department has chosen the alternative adopted after a review of numerous options because it is based on costs rather than charges. The department believes this approach will lessen the growth in medical costs in years to come. The department does not have statutory authority to establish its own PPO alternative.

Comment 9: The Montana State Fund (MSF) comments that ARM 24.29.1406(3) allows for a delay in payment while (4) requires payment in 30 days. The group suggests adding the language "Except as provided in (3)" to subparagraph (4) would eliminate any confusion.

Response 9: The department agrees and amends the rule as indicated below.

Comment 10: The MSF comments it would be helpful to clarify that the focus on bill payment is based on the insurer's liability for the condition versus the claim as insurers are not liable for unrelated conditions even though the injury or occupational disease is accepted. It suggests adding "for the condition" to ARM 24.29.1406(4) in the second sentence so it reads: "In cases where there is not dispute over liability for the condition, the insurer must…".

Response 10: The department agrees and amends the rule as indicated below.

Comment 11: The MSF suggests ARM 24.29.1406(5) be amended to clarify that insurer-initiated medical necessity review involves audits of bills not claims. The group comments it views a "claim" as an injury or condition, not a charge for medical services. Changing "claim" to bill audit in (5) makes this distinction.

Response 11: The department agrees and amends the rule as indicated below.

Comment 12: The MSF suggests ARM 24.29.1406 be amended to add the following: "(6) Facilities must within 30 days of receipt of a request from an insurer, return any overpayment due the insurer as the result of an audit or review procedure, unless mediation is initiated within the 30 days." The group explains the addition of (6) ensures the time value of money for both insurers and providers is considered in payments or refunds.

Response 12: The department agrees that both providers and payers have an interest in the time value of money. However, the department's proposed rule was designed to address the problem of delays in payment by insurers to providers that were brought to the attention of the department by providers. Further, the department is proposing legislation to address this issue for both providers and payers in the next session of the Legislature because the provision of any penalty for nonpayment must be authorized by statute.

Comment 13: The MSF comments there is a potential for implant overpayment based on the proposed payment methodology and suggests the following additions to New Rule I:

For those device intensive procedures listed on the OPPS 2008 Device Intensive Table 56, the following applies:

(1) Determine the portion of the APC payment that is allocated to the device from Table 56.

(2) Multiply the APC payment posted for the appropriate place of service (hospital outpatient or ambulatory surgery center) by the device percentage from Table 56.

(3) Remove the device portion from the total APC payment.

(4) The result is the "service" portion of that APC payment. (Unless the APC is status T, no further reductions to the APC payment apply.)

(5) Payment for the device is made by multiplying the invoice cost by 115 percent.

(6) The appropriate payment for the procedure, then, is the sum of step 4 and step 5.

Response 13: The department acknowledges that the fee schedule reimbursement procedure for implants with a cost over the threshold does not remove a portion of the payment from the APC or MS-DRG reimbursement amount to compensate for the additional reimbursement for the implant. However, the department chose the adopted procedure without the above modification in order to simplify the procedure. The department also intended to assure adequate compensation for providers as some providers indicated that devices are not adequately accounted for in the APCs. The budget neutral design of the fee schedule assumes that separate reimbursements for implants will not be subtracted from the CMS codes. The department will monitor this issue in the future.

Comment 14: The Montana Contractors Compensation Fund (MCCF) and Midland Claims Service (MCS) commented that they are opposed to mandatory electronic billing because they believe it will be too difficult for self insured entities. They assert it would place an undue financial burden on small claims processing operations by having to upgrade software and hardware.

Response 14: The intent of the rule is to encourage electronic billing as much as possible, but the rule also makes clear that electronic billing is not mandatory. Payers who currently receive billing manually will continue to do so.

Comment 15: The MCCF comments that not providing medical notes with billing takes away the payer's right to determine compensability and places it in the hands of the medical providers whose only obligation is to treat injured people. Paying without knowing what is being paid is not good business and has the potential to force payers into hiring additional personnel or paying third party providers to process information based on the rule change. MCCF also recommends tabling the rule until the issues it raises have been resolved and self insureds are not placed in a disadvantaged position by default.

Response 15: The commenter's assumption that a facility does not have to provide medical notes is incorrect. Insurers may request that notes or reports be sent. The department notes that the physician(s), who bills separately with a CPT code, will routinely be providing notes. The department also notes that in many instances, the procedures performed at a facility will have been pre-approved by the insurer, and thus should not come as a surprise. The department concludes that the rule changes being adopted do not take away any of the rights of any party. Insurers (payers) will still have an opportunity to dispute liability for a given procedure. The department notes that insurers and providers who have disputes that cannot be settled informally currently have the ability to have the dispute resolved via an adjudicatory process, and that does not change as a result of the adoption of the proposed rule changes. Because the underlying premise of the commenter is erroneous, the department declines to "table" the rules package.

Comment 16: The MCCF and MSC comment the rules do not have a mechanism or provision for timely refund from medical providers and that most Plan 1 organizations, whether self-administered or by TPAs, have no accounts receivable staff for pursuing collection of monies from hospitals and surgery centers. The groups point out this process, which does not exist under current rules, will be necessary to pursue 'timely' reimbursement of overpayments. When requiring payments be made within 30 days with no supporting documentation (medical reports), the number of overpayment reimbursements will rise dramatically. They also assert this creates a potential for placing payers in a disadvantaged position as payers will have to make all requests for records when it should be provided as a matter of course. The groups further comment the requirement to timely pay providers has the potential of tying up large amounts of funds for months and in some cases years for any disputes.

Response 16: The department notes that currently, under 39-71-608, MCA, and 39-71-615, MCA, payers are already allowed to pay medical claims without assuming liability. See also the response to Comment 12.

Comment 17: The MCCF states the new system shifts compensability determinations to a hospital to find the best code in order to get a bill paid and it creates a presumption of liability when the payer in order to comply pays for treatment that may not have been compensable. This creates a new set of issues if the claimant is represented and in fact will send more claims to litigation over bill confusion. The group further comments the change is one-sided and the only group benefiting is the medical providers.

Response 17: The department notes that when liability is accepted, the choice of coding does not create presumption of liability. Further, many workers' compensation procedures are preauthorized and therefore the records are not always necessary for bill payment. In addition, the department notes that ARM 24.29.1404 allows payers to obtain any necessary records when there is a dispute regarding the amount payable to medical providers, the access to medical records, the timeliness of payments to medical providers, or the requirements for documentation from medical providers. Finally, the department notes it believes the advantages of switching to a cost based system outweigh the disadvantages. See also response to Comment 16.

Comment 18: MCS comments the proposed rules will cause a significant hardship and potential liability exposure for Plan No. 1 self-insured and other self-administered workers' compensation programs. It further comments that paying medical bills without the notes and invoices may cause TPAs to be in violation of their contracts. The group recommends that the rule change be stopped and significant amendments to the facility fee schedule rules be considered prior to implementation. The group cites the following issues of concern or objections: medical reports not transmitted with medical billing; requirement that facility medical bills be paid within 30 days of receipt; presumption that the only fee audit be conducted postpayment; no express requirement for audit adjustments to be reimbursed by facility; no time requirements for audit adjustment reimbursements; no time requirements for billing by facilities (date of service to billing date); no tracking of or administrative or legal recourse for facility bill coding errors or fraud; no express requirement that medical reports be provided by facilities; no requirement that medical reports to support facility bills be provided by facilities at no charge; no funding mechanism to reimburse self-insured and self-administered Montana WC programs for additional costs for staffing, software, and other related costs of implementing the system as proposed; and no immunity or legal presumptions to protect payers from allegations that a claim is "deemed accepted" simply because a facility bill was paid pursuant to the proposed rules.

Response 18: The department rejects the suggestion of the commenter that the proposed rule changes will somehow more significantly affect Plan No. 1 self-insured employers and groups than they will affect other insurers. The department

notes that the provisions of the existing statutes and medical services rules address a variety of the commenter's concerns, including 39-71-604, MCA, ARM 24.29.1404, 24.29.1406, and 24.29.1513 among others. In addition, by reference to other responses (see Responses 9, 10, 11, 12, 14, 15, 16, and 17), the department believes that the commenter's concerns have generally been addressed. The department intends to monitor the implementation and application of the facility rules to determine what, if any, modifications to the rules appear appropriate and necessary.

Comment 19: The MHA commented that it supports switching to an MS-DRG and APC type system. However, it asserts the proposed fee schedule based on CMS coding would be easier to implement if the Montana MS-DRG and APC codes were updated in sync with the Medicare annual and quarterly code updates.

Response 19: The department agrees and is pursuing legislation in the next session to allow the medical coding updates to occur automatically in Montana. Further, the department has updated its web site reimbursement tables to include the most recently adopted CMS codes. The changes from the initial proposal include splitting one MS-DRG into two separate MS-DRGs. Because the weights of the DRGs are relative, this also changed the relative weights and reimbursement amounts of all the final adopted DRGs. Finally, the department has added minor changes on its web site regarding the status indicator codes to make clear that although some CMS status indicator codes that the department has not adopted appear on the tables, those codes are not to be used in calculating reimbursement.

Comment 20: The MHA has requested to see the data that the department is using to design the fee schedule.

Response 20: The department will provide appropriate data that do not include proprietary information.

Comment 21: One commenter suggested that facilities be defined using FEIN numbers rather than following the statutory definition in Title 50, MCA. The commenter asserted that the definition in Title 50, MCA, is a long all-inclusive list that is complex.

Response 21: The department disagrees with using FEIN numbers because that would include facilities the department does not intend to include with acute care hospitals. Further, the chosen definition is consistent with current Montana law and is understood and used by providers. The department will consider issues with other types of facilities providing workers' compensation care as those issues arise.

Comment 22: MCS comments that it is concerned the new system will encourage fraudulent provider billing and that it has no protection from such a problem. It argues that it does not have the same protections as Plan 2 and 3 insurers.

Response 22: The department believes there is sufficient protection from fraud in the criminal code. The department notes there is no specific protection for private insurers in the Workers' Compensation Act. The department also notes that such an issue would have to be addressed statutorily if problems do arise.

4. The department has amended the following rules as proposed, but with the following changes from the original proposal, stricken matter interlined, new matter underlined:

24.29.1406 FACILITY BILLS (1) Facility bills should be submitted when the injured worker is discharged from the facility or every 30 days.

(2) To the extent possible, electronic billing must be utilized by both providers and payers in the billing and reimbursement process to facilitate the rapid transmission of data, lessen the opportunity for errors, and lessen system costs.

(3) It is the responsibility of the facility to use the proper service codes on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment until proper coding of the services provided is received by the insurer.

(4) Except as provided in (3), ~~Insurers~~ insurers must make timely payments of facility bills. In cases where there is no dispute over liability for the condition, the insurer must, within 30 days of receipt of a facility's charges, pay the charges according to the rates established by these rules.

(5) Insurer-initiated medical necessity review, ~~claim~~ bill audits, and other administrative review procedures may only be conducted on a postpayment basis.

AUTH: 39-71-203, MCA
IMP: 39-71-105, 39-71-107, 39-71-203, 39-71-704, MCA

24.29.1427 HOSPITAL SERVICE RULES FOR SERVICES PROVIDED FROM JANUARY 1, 2008, THROUGH ~~OCTOBER 31, 2008~~ NOVEMBER 30, 2008

(1) This rule applies to services provided from January 1, 2008, through ~~October 31, 2008~~ November 30, 2008.

(2) and (3) remain as proposed.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

24.29.1431 HOSPITAL RATES FROM JULY 1, 2001, THROUGH ~~OCTOBER 31, 2008~~ NOVEMBER 30, 2008 (1) through (3) remain as proposed.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

5. The department has adopted the following rule as proposed, but with the following changes from the original proposal, stricken matter interlined, new matter underlined:

NEW RULE I (ARM 24.29.1432) FACILITY SERVICE RULES AND RATES FOR SERVICES PROVIDED ON OR AFTER ~~NOVEMBER~~ DECEMBER 1, 2008

(1) The department adopts the fee schedules provided by this rule to determine the reimbursement amounts for medical services provided at a facility when a person is discharged on or after ~~November~~ December 1, 2008. An insurer is obligated to pay the fee provided by the fee schedules for a service, even if the billed charges are less, unless the facility and insurer have a managed care organization (MCO) or preferred provider organization (PPO) arrangement that provides for a different payment amount. The fee schedules, available on-line via the internet at http://erd.dli.mt.gov/wcregs/medreg.asp, are comprised of the following elements:

(a) The Montana Hospital Inpatient Services MS-DRG Reimbursement Fee Schedule, based on CMS version 26;

(b) through (10)(b) remain as proposed.

(11) The following applies to inpatient services provided at an acute care hospital:

(a) The department may establish the base rate annually.

(i) Effective ~~November~~ December 1, 2008, the base rate is $7,735.

(b) through (d)(ii) remain as proposed.

(e) Where an implantable exceeds $10,000 in cost, hospitals may seek additional reimbursement beyond the normal MS-DRG payment. Any implantable that costs less than $10,000 is bundled in the implantable charge included in the MS-DRG payment.

(i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.

(ii) through (g)(iii) remain as proposed.

(12) The following applies to outpatient services provided at an acute care hospital or an ASC:

(a) The department may establish the base rate for outpatient service at acute care hospitals annually.

(i) Effective ~~November~~ December 1, 2008, the base rate for hospital outpatient services is $105.

(b) The department may establish the base rate for ASCs annually.

(i) Effective ~~November~~ December 1, 2008, the base rate for ASCs is $79, which is 75 percent of the hospital base rate.

(c) through (e) remain as proposed.

(f) Where an outpatient implantable exceeds $500 in cost, hospitals or ASCs may seek additional reimbursement beyond the normal APC payment. In such an instance, the provider may bill CPT code L 8699, and the status indicator code "N" may not be used by a payer to determine the amount of the payment. Any implantable that costs less than $500 is bundled in the APC payment.

(i) Any reimbursement for implantables pursuant to this subsection must be documented by a copy of the invoice for the implantable. Insurers are subject to privacy laws concerning disclosure of health or proprietary information.

(ii) through (g)(iii) remain as proposed.

AUTH: 39-71-203, MCA

IMP: 39-71-203, 39-71-704, MCA

6. The department has amended ARM 24.29.1402, 24.29.1404, 24.29.1416, 24.29.1430, and 24.29.1522 exactly as proposed.

7. The department has amended and transferred ARM 24.29.1504 to ARM 24.29.1401A exactly as proposed.

8. The amendments, amendments and transfer, and adoption are effective December 1, 2008.

/s/ MARK CADWALLADER	/s/ KEITH KELLY
Mark Cadwallader	Keith Kelly, Commissioner
Alternate Rule Reviewer	DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State on November 17, 2008.